EYECARE PHYSICIANS & SURGEONS PATIENT INFORMATION QUESTIONNAIRE

Patient name: _____________________________ Age:_____ DOB:_____________ Sex: M/F
Address:_____________________________ City: ____________________ State: _____ Zip:_________
Home Phone: (____)___________________ Cell Phone: (____)___________________
Occupation:_____________________________ Referring Physician:_____________________

Eye History

	Yes	No		Yes	No
Blurred vision	□	□	Lazy eye	□	□
Burning	□	□	Light sensitivity	□	□
Cataracts	□	□	Macular degeneration	□	□
Crossed eyes	□	□	Redness	□	□
Double vision	□	□	Retinal disease	□	□
Dry eyes	□	□	Vision loss	□	□
Flashes/floating spots	□	□	Watering	□	□
Glaucoma	□	□	Other (please specify)______________________		
Itching	□	□	Eye Surgery (please specify)_________________		

Other Medical History

	Yes	No		Yes	No
Allergies	□	□	High blood pressure	□	□
Arthritis	□	□	Kidney disease	□	□
Asthma or other lung disease	□	□	Intestinal, stomach, or liver disease	□	□
Bleeding disorder	□	□	Are you pregnant?	□	□
Cancer(__________)	□	□	Psychiatric disorder	□	□
Diabetes	□	□	Skin condition	□	□
Headaches	□	□	Stroke	□	□
Heart Disease	□	□	Thyroid disease	□	□
HIV/AIDS	□	□	Other (please specify)______________________		

Medications/Allergies

Please list any medications that you are currently taking, including eyedrops:

____
____
____

Men: Do you now, or have you ever used the prostate medication Flomax? □ Yes □ No

Please list any allergies to medications or other substances:

____
____

Family/Social History

Do you have a family history of eye disease or other medical conditions? (Please specify):

____

Tobacco use □Never Smoked □Former Smoker □Current Smoker
Alcohol use □Yes □No **Chemical dependency** □Yes □No

Pharmacy

Pharmacy Name_____________________________ Address___________________________________
Zip code_____________________________________ Phone_____________________________________